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ADMINISTRATIVE OFFICE OF THE COURTS
PRETRIAL SERVICES RECORDS DIVISION
100 MILLCREEK PARK
FRANKFORT, KENTUCKY 40601
502-573-1682 or 800-928-6381
pretrialrecords@kycourts.net

The process to obtain the information contained in the CourtNet Disposition System is as follows:

Individuals Requesting a record on yourself requires a $10.00 fee **(check or money order)**. Enclose a self addressed stamped envelope for a return reply.

Nonprofit
Health Care Housing Auth. Requesting a record on individuals requires a $10.00 fee **(check or money order)** and your nonprofit number (Form #51-A-126). Your return envelope must be addressed with adequate postage, and the other envelope only needs the address of the person being checked.

Licensing/ Others A request for licensing purposes and on another person requires a $10.00 fee **(check or money order)** and must include two envelopes. Your return envelope must be addressed with adequate postage, and the other only needs the address of the person being checked.

Government Government entities must provide both envelopes mentioned above, a tax exempt number for waiver of fees, contact person, phone number, and mailing address on their request. Multiple inquires can be made on a continuation form.

Fees are paid to the order of the KENTUCKY STATE TREASURER by check or money order ONLY. FAILURE TO COMPLY WITH THESE PROCEDURES WILL RESULT IN THE REQUEST BEING RETURNED UNPROCESSED. If you suspect information contained on the record is incorrect, or have any questions, please contact Pretrial Services Records Division at (502) 573-1682 or (800) 928-6381.

PLEASE PRINT OR TYPE THE INDIVIDUALS INFORMATION CLEARLY.

SOCIAL SECURITY NUMBER: _____

NAME: _____

DATE OF BIRTH: _____

MAIDEN OR ALIAS NAMES: _____

STREET ADDRESS / P.O. BOX: _____

CITY, STATE, ZIP CODE: _____

E-MAIL ADDRESS: _____

I understand the information supplied by me must be truthful and falsification with an intent to mislead may result in my prosecution under KRS. 523.100. I have provided the basic information necessary to qualify for record processing and exemption of fees - **if applicable**.

_____ Individual's Signature

_____ Date

_____ Non-Profit Number (Form 51-A-126), or Tax Exempt Number

_____ E-mail address(sent to this e-mail only)

Would you like the CourtNet Records e-mailed? ☐ Yes ☐ No

_____ Company

_____ Telephone Number

_____ Requestor/Contact Person

Please denote which purpose applies to this request:
- ☐ Employment
- ☐ Criminal Investigation
- ☐ Screening Housing Applicants
- ☐ Volunteer/Care over Juvenile
- ☐ Licensing
- ☐ Other (please explain) _____

_____ Address

_____ City, State, Zip

Louisville Metro Senior Nutrition Program

CONFIDENTIALITY AGREEMENT

VOLUNTEER – STUDENT/INTERN

I, the undersigned, understand that during the course of participating in the Senior Nutrition Program, I may learn client or agency information that is confidential. By signing this document, I am agreeing to comply with all regulations and laws established to protect confidential information. I understand that accessing or releasing confidential information or causing this to occur outside the course of my responsibilities, as a volunteer would constitute a violation of this agreement. I understand that proven violation of this agreement can result in termination of my access to information.

Confidential information shall include but not be limited to:

- activities I observe or in which I participate in the Senior Nutrition Program
- verbal or written information to which I have access that pertains to clients, staff, volunteers, agencies, or committees;
- all documents relating to the above.

I agree to:

- maintain confidential information and not reveal it to clients, colleagues or others with whom I interact;
- utilize information disclosed to me solely for the purpose of providing and enhancing services to the Senior Nutrition Program;
- restrict disclosure to those staff, volunteers or committee members who have a need to know and advise them of their concomitant duty to not disclose confidential information to a third party.

I recognize that I have a duty to report or see to the reporting child and adult abuse, neglect or exploitation, an individual being in danger of hurting self or others and, within professional guidelines, ethical or statutory violations.

I have read and understand this Confidentiality Statement and by signing in the space below agree to its terms and conditions.

Print Name: _____

Signature: _____

Capacity: _____

Date: _____

Louisville Metro Department of Housing & Family Services
Community Action Partnership
SENIOR NUTRITION
VOLUNTEER APPLICATION

APPLICANT INFORMATION			
Applicant Name		DOB	Age
Street Address			
City	State	Zip Code	
Home Phone	Work Phone	Alternate Phone	
Email		Use email as contact ❑ Yes ❑ No	

OCCUPATION INFORMATION		
Occupation	Working Hours	Retired ❑ Yes ❑ No

VOLUNTEER AVAILABILITY INFORMATION		
Time Available To Volunteer	Days Available M ☐ T ☐ W ☐ TH ☐ F ☐	Do you have a car? ❑ Yes ❑ No

PERSONAL REFERENCES			
Name	**Address**	**Phone**	**Zip Code**

SIGNATURE	
I confirm the information on this application is accurate and complete to the best of my knowledge.	
Applicant Signature	Date

OFFICE USE ONLY		
Date Received	Training Date	KIPDA Training Returned ❑ Yes ❑ No
# of Coolers	# of Hot Packs	# of Cold Packs
Verified Drivers License ❑ Yes ❑ No		Verified Auto Insurance ❑ Yes ❑ No
Staff Signature		Date

Louisville Metro Government

Agreement to Volunteer
And Accept Worker's Compensation Benefits

Louisville/Jefferson County Metro Government ("Metro Government") and _____ **("Volunteer")** agree as follows regarding volunteering and acceptance of Workers' Compensation coverage:

1) Volunteer agrees to perform volunteer services as directed by Metro Government and to follow Metro policies and procedures.

2) Metro Government agrees to provide Workers' Compensation coverage to the Volunteer pursuant to the Kentucky Workers' Compensation Act (KRS 342, *et seq.*), for any injuries sustained during any authorized volunteer services performed on behalf of Metro Government. Metro will pay for all medical expenses incurred by Volunteer for covered injuries, with no applicable deductible or co-payments by Volunteer, in exchange for receiving voluntary services.

3) Volunteer accepts the coverage of the Workers' Compensation Act as the sole remedy for any damages he/she suffers from any and all services performed for the Louisville/Jefferson County Metro Government and agrees not to seek any damages not covered by the Workers Compensation Act, in exchange for being provided this free coverage.

Louisville/Jefferson County Metro Government Department: _____

Supervisor: _____

Volunteer – Signature: _____

Volunteer Name – Print: _____

Address: _____

Date: _____

For Volunteers under Age 18: Age of Volunteer: _____

If the Volunteer is under the age of 18 years, his or her parent must sign below.

Parent or Guardian Signature: _____

Parent or Guardian Name-Print: _____